

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

01771

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County *Hanford*City or town *White Hall, R.F.D. Ind.*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *17 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bettie J. Anderson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female white widowed
& Thomas Anderson*

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) *June 24 - 1864*

8. AGE:

Years

Months

Days

If less than one day

90

7

20

hrs.

min.

9. Birthplace

Rocky Harford Co Ind
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name *Hughes Osga Anderson*

13. Birthplace

Unknown

MOTHER

14. Maiden name *Hannah Hayes*

15. Birthplace

Rocky Md.

16. Informant

Mrs. Thom Anderson

Address

White Hall, Ind

17. Burial

Data thereof *FEB 18 1945*
(month) (day) (year)

Cemetery or crematory

Bethel

Location

White Hall, Ind

18. Funeral director

Howard & Mahlau

Address

White Hall Ind

19. Date rec'd by registrar

Feb. 17 1945

Thomas R. Brown

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ind*

County

City or town *White Hall R.F.D. Ind*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 14 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I intended deceased from

Jan 2 1945 to Feb 14 1945
and that I last saw her alive on *Feb 13 1945*

Immediate cause of death

Colitis acute

DURATION

Due to

Eastern enteritis

Due to

Arteriosclerosis

DURATION

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

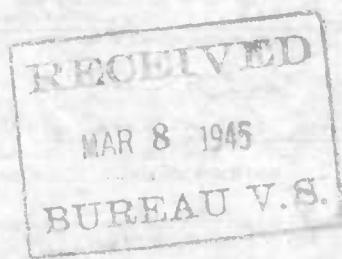
Gunshot

Injured at work?

23. SIGNATURE

M. D. or other

Address *Stewartstown*Date signed *Feb 15 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

01772

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: Harford
 County: _____
 City or town: Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, Institution, or street address where death occurred: 350 Bourbon St
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md. County: Harford
 City or town: Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 350 Bourbon St
 (If rural, give LOCATION)

3. (a) FULL NAME

May Fields Baldwin

3. (b) Social Security Number _____

4. Sex: Female Color or race: White 6. (a) Single, married, widowed, or divorced: Widowed

B. (b) Name of husband or wife: Monroe Baldwin7. Birth date of deceased (mo., day, yr.): Feb. 13, 1855 6. (c) If alive, give age: _____ years8. AGE: Years: 89 Months: 11 Days: 28 If less than one day: _____ hrs. _____ min.9. Birthplace: Penn (Town, county, and state)10. Usual occupation: House Duties11. Industry or business: Cornelius P. Fields12. Name: Cornelius P. Fields 13. Birthplace: Penn14. Maiden name: Mary S. Fields 15. Birthplace: Penn16. Informant: Mr. Harford Baldwin Address: Havre de Grace Md.17. Burial: Burial Date thereof: Feb 13, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: Angel Hill Location: Havre de Grace Md.18. Funeral director: R. Madison Mitchell Address: Havre de Grace Md.19. Date rec'd by registrar: Feb. 12 1945 A. L. Lewis m.d. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11 1945 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1944 to Feb. 10 1945 and that I last saw her alive on Feb. 10 1945.Immediate cause of death: Chronic bronchitisDue to: Chronic bronchitis

Due to: _____

Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

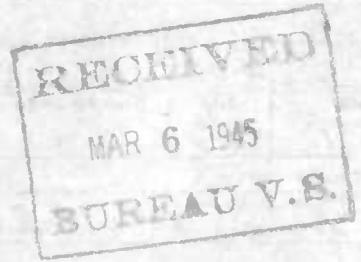
Accident, suicide, or homicide: _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: A. L. Lewis M.D. M. D. or other _____Address: Havre de Grace Md. Date signed: Feb. 12 1945



M

MARGIN RESERVED FOR BINDING

1

2

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

01773

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County.....

Harford
Prestonville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sallie Blaney

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Single

Black

Widowed

6.(b) Name of husband or wife.....

Frank Blaney

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

about 85 yrs

hrs.

min.

9. Birthplace.....

Harford Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Housekeeping

MOTHER FATHER

12. Name.....

Don't know

13. Birthplace.....

Don't know

14. Maiden name.....

Alice Bonds

15. Birthplace.....

Harford Co. Md.

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Gates Hill

Location.....

Rock MD

18. Funeral director.....

J. Young, Kiff

Address.....

Farm Ave Pa

19. Date rec'd by registrar.....

Feb 14

1945 Thomas R. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 10

19

45 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 18, 1946, to Feb 10, 1945, and that I last saw her alive on Feb 9, 1945.

Immediate cause of death.....

Congestive Heart Failure

DURATION

2 days

Due to..... Arterio-sclerotic C-V disease

5 yrs

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

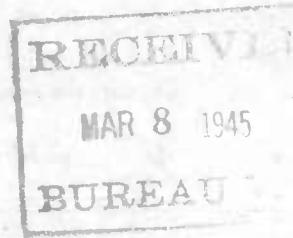
Means of injury.....

Injured at work?

23. SIGNATURE.....

Sarah G. Hunt, M.D.
Cardiff, N.Y. Date signed 2/10/45

M. D. or other



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01774

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Feb. 5, 1875

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

19. M. D. or other

Address.....

Date issued.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th 1945 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 4th 1945 to Feb. 8th 1945and that I last saw her alive on Feb. 4th 1945

Immediate cause of death Cerebral Hemorrhage DURATION

4 days

Due to.....

Due to.....

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

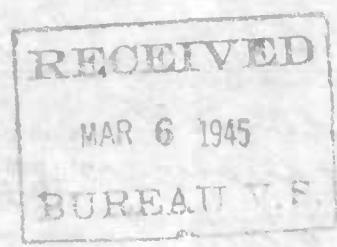
Injured at work?

23. SIGNATURE A. F. Van T. Fisher

M. D. or other

Address Bel Air, Md.

Date issued Feb. 9, 1945



7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 01775/81

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 6 months

Hospital, institution, or street address where death occurred:

Station Hospital, Aberdeen Proving Ground,

Md.

How long in hospital or institution? 1 day

3. (a) FULL NAME

MAX STUART CAMPBELL

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W M

6. (b) Name of husband or wife Norma E. Campbell

7. Birth date of deceased (mo., day, yr.) 19 April 1907 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
37 9 24 hrs. min.9. Birthplace Battle Creek, Michigan
(Town, county, and state)

10. Usual occupation Mechanic - Auto

11. Industry or business

FATHER 12. Name Roy D.

13. Birthplace Michigan

MOTHER 14. Maiden name Lutie Rand

15. Birthplace Minnesota

16. Informant The Surgeon

Address Station Hospital, APG, Md.

17. Burial or cremation Date thereof Feb 14 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Crematory or cemetery Hobbles Funeral Home

Location W Michigan Ave Battle Creek Mich.

18. Funeral director Howard K. McCombe Son

Address Abingdon Maryland

Feb 14 1945 Tellie H. Riley

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Michigan County Calhoun

City or town Battle Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 W. Van Buren St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

366-07-4531

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 February

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 February 1945 to 13 Feb 1945

and that I last saw him alive on 13 February 1945

Immediate cause of death Thrombosis, coronary, artery, acute

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results Myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

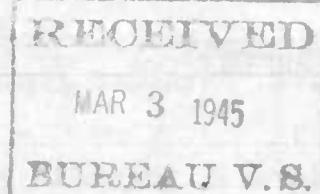
23. SIGNATURE

A. D. HOFFMAN / 1st Lt. MC M. D. or other

Address Station Hospital, APG, Md. Date signed 13 Feb 45

RECEIVED BY THE LIBRARY OF THE CHAMBER

RECEIVED BY THE LIBRARY



RECEIVED
MAR 8 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Harford
Whitfield Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 74 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Robert H. Davis

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife..... Anne E. Davis

7. Birth date of deceased (mo., day, yr.)

Jan. 30 - 1871

6.(c) If alive, give age..... 63 years

8. AGE:

Years

Months

Days

If less than one day

74 0 7

hrs. min.

9. Birthplace.....

Harford Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

John Davis

12. Name.....

John Davis

13. Birthplace.....

Harford Co. Md.

14. Maiden name.....

Elizabeth Dick

15. Birthplace.....

Harford Co. Md.

16. Informant.....

Bertha Davis Hughes

Address.....

Whitfield, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Southern Cemetery

Location.....

Dublin, Md.

18. Funeral director.....

Hubert P. Harris

Address.....

Delta, Pa.

19. Date rec'd by registrar.....

Feb. 10 1945

(Date rec'd by registrar)

Carl E. Knapp

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Whitfield Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... February 7 1945 at 11⁰⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1944 to Feb 7 1945

and that I last saw h. alive on Feb 7 1945

Immediate cause of death.....

Bronchopneumonia

Due to.....

Due to.....

Other conditions..... Generalized arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Josiah A. Hunt M.D. M. D. or other

Address..... Cardiff, Md. Date signed..... 2/8/45

RECEIVED

APR 10 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITIZEN CORPORATION LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

01778
Reg. Dist. No. 185

1. PLACE OF DEATH:
County..... Harford
City or town..... Havre de Grace, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 3 months
Hospital, institution, or street address where death occurred:..... Harford Memorial Hospital
How long in hospital or institution?..... 1 hr. and 50 min.

3. (a) FULL NAME
Henry Morgan DiMarco

4. Sex Male	5. Color or race W	6.(a) Single, married, widowed, or divorced Single
----------------	-----------------------	---

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)
December 27, 1944
..... 6.(c) If alive, give age..... years

8. AGE: Years 2 MOS.	Months	Days	If less than one day hrs. min.
-------------------------	--------	------	---

9. Birthplace..... Havre de Grace, Harford Co., Md.
(Town, county, and state)

10. Usual occupation..... Nurse

11. Industry or business
12. Name..... Henry DiMarco

MOTHER FATHER
13. Birthplace..... Havre de Grace, Md.

MOTHER
14. Maiden name..... Dorothy L. Cullum
15. Birthplace..... Aberdeen, Maryland

16. Informant..... Henry DiMarco - Father
Address..... 415 N. Stokes St., City

17. Burial
(Burial, cremation, or removal. Which?) Date thereof..... Mar. 2 - 1945
(month) (day) (year)

Cemetery or crematory..... Calvary

Location..... Cromwell Harford Co. Md.

18. Funeral director..... Henry Jennings Sons

Address..... Aberdeen Md

19. 3-1
(Date rec'd by registrar) 1945 G. L. Louis M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Harford
City or town..... Havre de Grace,
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 415. N. Stokes Street
(If rural, give LOCATION)
2.(a) If veteran, name war..... World

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

2-26-45

20. DATE OF DEATH
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2/25 1945 to 2/26 1945
and that I last saw him alive on 2/26 1945

Immediate cause of death.....
Due to..... Sepsis Pneumonia
Streptococcus Throat

Due to..... Cardiac Failure

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

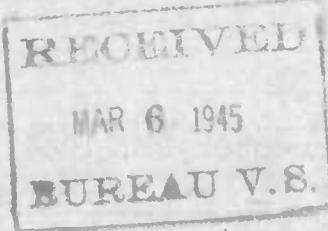
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Charles H. Kelly M.D.
M. D. or other

Address..... 1100 N. Charles St. Date signed..... 2/27/45



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WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

01779

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH:

County NarffordCity or town Hawke for Acre

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 daysHospital, Institution, or street address where death occurred: Hawford Memorial Hosp.How long in hospital or institution? 8 days

3. (a) FULL NAME

Catherine Dolan.4. Sex: F Color or race w 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife John Dolan.7. Birth date of deceased (mo., day, yr.) Nov. 28, 1867 1867 8. (c) If alive, give age 69 years8. AGE: Years 77 Months 77 Days 2 If less than one day 5 hrs. min. 9. Birthplace England England. (Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home.12. Name Jacob Clark13. Birthplace England14. Maiden name McKeehan15. Birthplace England16. Informant Deceased + m. John E. O'BrienAddress Abberdeen Md.17. Burial Date theretofore Feb. 6 - 1945(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. FrancesLocation Abingdon Md.18. Funeral director Sandy Tanning SonsAddress Abberdeen Md.19. Date rec'd by registrar Feb. 5 1945(Date rec'd by registrar) A. L. Lewis M.D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty AberdeenCity or town Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) None2.(a) If veteran, name war 3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 6:57 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-27 1945 to 2-3 1945and that I last saw her alive on 2-3 1945

Immediate cause of death

Cardiorespiratory failureDue to Hepostatic congestion of lungsDue to Senile debilityOther conditions Pneumonia

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Legion M.D.M. D. or other Surgeon General M.D.Address Abberdeen Md. Date signed Feb 3 1945

BRANCH TO THE INTERAMERICAN STATE GRAPPLERS

RECEIVED AND INDEXED

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01780

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County..... *Harford*City or town..... *Near - Bel Air Md*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... *23 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Evalena H Durham

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

*M*6. (b) Name of husband or wife..... *Jacob G Durham*

7. Birth date of deceased (mo., day, yr.)

Dec 11 1867

6. (c) If alive, give age..... years

8. AGE:

Years
77

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Harford

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name..... *John Hanna*

13. Birthplace

Harford Co

14. Maiden name.....

Hucatia Mechan

15. Birthplace

Harford Co

16. Informant.....

Jacob G C Durham

Address

Bel Air

17. Burial

(Burial, cremation, or removal, which?)

Date thereof..... *Feb 21/45*

(month) (day) (year)

Cemetery or crematory

Mt Zion

Location

Fountain Green

18. Funeral director.....

Dean's Funeral

Address

*Bel Air Md*19. *2/21*

1945

Date rec'd by registrar..... *Priscilla Lovord*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md*County..... *Harford*City or town..... *Bel Air Md (Rural)*
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 18 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb 7 1945 to Feb 18 1945*and that I last saw her alive on *Feb 18 1945*

Immediate cause of death.....

Coronary Occlusion

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

V

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

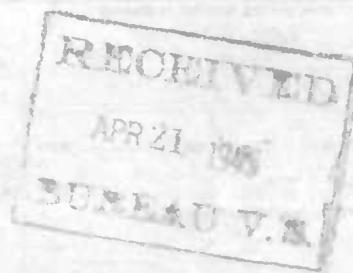
Injured at work?

23. SIGNATURE

L.P. Bruegrass

M. D. or other

Address..... *Norington Md* Date signed *2/19/45*



~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.~~

~~THIS CORPORATION LIMITED TO~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *M.D.*

01781

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
 County Harford
 City or town Hare de Grace
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 hrs. 40 min.
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 7 hrs. 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Maryland County Edgewood
 City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
 Street No.
(If rural, give LOCATION)

3. (a) FULL NAME
Emma M. Fletcher

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>INFANT</u>
----------------------	-------------------------------	--

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1945 years

8. AGE: Years	Months	Days	If less than one day 7 hrs. 40 min.
---------------	--------	------	--

9. Birthplace Hare de Grace, Harford, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER	12. Name <u>Frank John Fletcher</u>
	13. Birthplace <u>Penns.</u>

MOTHER	14. Maiden name <u>Lottie Irene Griffin</u>
	15. Birthplace <u>Harford Co., Md.</u>

16. Informant	<u>Mrs Frank J. Fletcher</u>
Address	<u>Edgewood, Md.</u>

17. Burial	Date thereof <u>Feb. 27, 1945</u> <small>(Burial, cremation, or removal, when)</small>
Cemetery or crematory	<u>Emory Cem.</u>

Location	<u>Harford Co., Md.</u>
----------	-------------------------

18. Funeral director	<u>A. S. Bailey</u>
Address	<u>Darlington, Md.</u>

19. Date rec'd by registrar	<u>Feb. 25 1945</u>	<u>A. L. Lewis M.D.</u>
		Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 24 1945 to Feb 24 1945
 and that I last saw her alive on Feb 24 1945

Immediate cause of death

Pneumonia atelectasis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

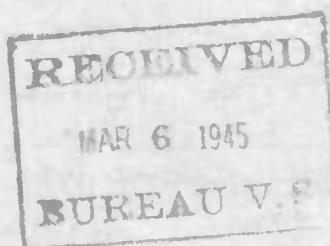
Means of injury

Injured at work?

23. SIGNATURE Ralph Harley Jr.

M. D. or other

Address Chesapeake, Md. Date signed Feb 25



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information clearly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01782

CERTIFICATE OF DEATH

Reg. Distr. No. 182

1. PLACE OF DEATH:

County.....

City or town.....

Forest Park
Cherry Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

53 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Marie C. Grafton

4. Sex

Female white widow

5. Color or race

b.(a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

John C. Grafton

7. Birth date of deceased (mo., day, yr.)

July 1863

6. (c) If alive, give age..... years

8. AGE: Years

81

Months

7

Days

—

If less than one day

hrs. — min.

9. Birthplace

Saline Hard Co Ark

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Walter Cunningham

FATHER

12. Name

13. Birthplace

Baltimore Md.

MOTHER

14. Maiden name

Maria Troutner

15. Birthplace

Jord

16. Informant

Raymond A. Grafton

Address

Magnolia Arkansas

17. Burial

Date thereof

Feb 27-45

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date read by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State.....

Md County Harford

City or town.....

Cherry Hill (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 25

1945 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1st 1945 to Feb 25 1945

and that I last saw her alive on Feb 25 1945

Immediate cause of death

Chr. Myocardial Disease 18 mos

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

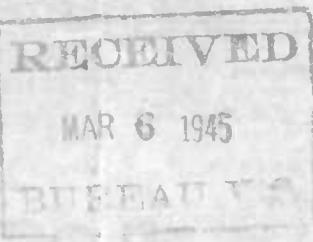
Means of injury

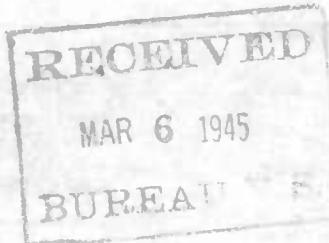
Injured at work?

23. SIGNATURE

M. D. or other

Address Forest Hill Md Date signed 2/26/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

01784

CERTIFICATE OF DEATH

Reg. Dist. No. 187

1. PLACE OF DEATH:

County.....

City or town.....

Harford
Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 45 years.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Jesse J. Healy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
84	2	2	hrs. min.

9. Birthplace..... Harford Co. Md.

(Town, county, and state)

10. Usual occupation..... Dentist

11. Industry or business

William Healy

12. Name..... Harford Co. Md.

13. Birthplace..... Harford Co. Md.

14. Maiden name..... Elizabeth Barr

15. Birthplace..... Harford Co. Md.

16. Informant..... Ernest Healy

Address 1207 E. 36th St. Baltimore

17. Burial..... Date thereof... Feb. 25 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... slate Ridge cemetery

Location..... Delta, Pa.

18. Funeral director..... Herbert P. Harkins

Address..... Delta, Pa.

19. Date rec'd by registrar..... Feb. 25 1945

(Date rec'd by registrar) Carl E. Knapp

2. USUAL RESIDENCE (HOME) OF DECEASED:

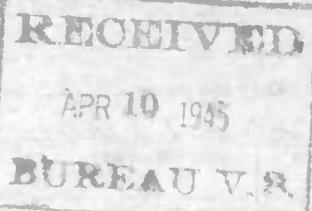
(For newborn infants give residence of mother)

State.....

City or town.....

Harford
Baltimore

Street No.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(B.P.O.)

01785

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County

City or town

Harford

Joppa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 year & 4 mos

3. (a) FULL NAME

Mr Aubrey Elbert Hylton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

8. (b) Name of husband or wife

Nina L. Hylton

6. (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.)

Dec 13 1910

8. AGE:

Years
34Months
1Days
26If less than one day
hrs. min.

9. Birthplace

(Town, county, and state)

Virginia

10. Usual occupation

Radio Instruction

11. Industry or business

MOTHER FATHER

Aubrey E. Hylton

13. Birthplace

Lloyd Co Virginia

14. Maiden name

Deneen Whitlow

15. Birthplace

Virginia

16. Informant

Nina L. Hylton

Address

Joppa, R.D. Md

17. Burial, cremation, or removal. Which?

Graveside

Date thereof Feb 12 1945
(month) (day) (year)

Cemetery or crematory

Richardson & Co.

Location

Christiansburg, VA

18. Funeral director

Howard K. McCormick

Address

Abingdon Maryland

19. Date rec'd by registrar

Feb 12 1945

(Date rec'd by registrar)

Marie M. Marshall

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

Harford

City or town Joppa (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

230-01-5955

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 9

1945

at 1150 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-2

1945

to 2-7

1945

and that I last saw him alive on

2-7

1945

Immediate cause of death coronary occlusion

DURATION

Due to chronic glomerulonephritis

19 yrs

Due to

Other conditions hypertension retinitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

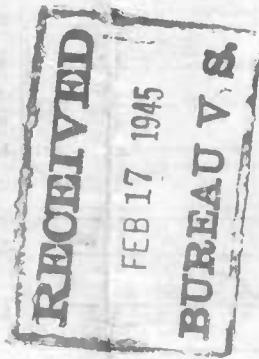
Fred O'Hodous, M.D.

M. D. or other

Address

Edgewood, MD

Date signed 2-9-45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468 *

01786
181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

*Baltimore**Aberdeen Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

117 Rogers St

How long in hospital or institution?

3. (a) FULL NAME

Susie M. Jacobs

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Female**White**Widow*

6. (b) Name of husband

Charles H. Jacobs

7. Birth date of deceased (mo., day, yr.)

Oct. 21 - 1885

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

*59**4*

hrs.

min.

9. Birthplace

8. 14

(Town, county, and state)

West Va

10. Usual occupation

12. 14

*Housewife**at home*

11. Industry or business

12. Father

13. Mother

14. Maiden name

15. Birthplace

16. Informant

17. Burial

18. Funeral director

19. Date rec'd by registrar

Address

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Means of injury

Injured at work?

Autopsy results

Physician

Date of op.

Date of

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

M. D. or other

Date signed

Feb 15/45

Date signed

Feb 15/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Baltimore*City or town.....*Aberdeen Md.* (If outside city or town limits, write RURAL and give nearest town)Street No.....*117 Rogers* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 13

1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 12

1945, to

Feb. 13

1945.

and that I last saw her alive on

Feb. 13

1945.

Immediate cause of death

*Carcinoma (Breast)
of the liver*

DURATION

Unknown

Due to

Due to

*Her disease regressed
after resection.*

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

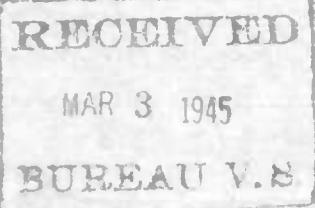
Means of injury

Injured at work?

23. SIGNATURE *Tev. P. Thompson*

M. D. or other

Address *Aberdeen Md.*Date signed *Feb 15/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 240

01787

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 6 days

3. (a) FULL NAME

LEVI COULD JENKINS

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Laura Jenkins

7. Birth date of deceased (mo. day, yr.) May 28 1895 6. (c) If alive, give age 49 years

8. AGE: Years 49 Months 8 Days 24 It less than one day hrs. min.

9. Birthplace Fairmont, West Virginia
(Town, county, and state)

10. Usual occupation Railroad Engineer

11. Industry or business U.S. Government

12. Name L.S. Jenkins

13. Birthplace Morgan Town, W. Virginia

14. Maiden name Thelma C. Jenkins

15. Birthplace Elgarden, Maryland

16. Informant The Surgeon

Address Aberdeen Proving Ground, Md.

17. Removal Date thereof Feb 23 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Cumberland Md

18. Funeral director Henry Taving Sons

Address

19. Feb 23 1945
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

220-10-7816

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 February 1945 at 5:17 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

17 February 1945, to 22 Feb 1945

and that I last saw him alive on 22 February 1945

Immediate cause of death Coronary Occlusion

and myocardial infarction

DURATION

Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results Confirm cause of death

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

A. D. HOFFMAN, 1st LT. M.C. or other

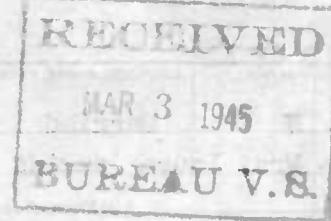
Address Station Hospital APG, Md. Date signed 23 Feb 45

MEMORANDUM FOR THE UNITED STATES CHIEF OF STAFF

RECORDED IN THE OFFICE OF THE SECRETARY OF STATE

TO: DIRECTOR FEDERAL BUREAU OF INVESTIGATION

FROM: SECRETARY OF STATE



1
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VS A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Rec'd*

CERTIFICATE OF DEATH

01788

184.

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

*Harford**Whitford*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*5 days.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

*Hugh A. Jones.*4. Sex *m.* 5. Color or race *w* 6.(a) Single, married, widowed, or divorced *Married.*6.(b) Name of husband or wife *Elizabeth Jones*7. Birth date of deceased (mo., day, yr.) *Nov. 20 1879* 8.(c) If alive, give age *63* years8. AGE: Years *65* Months *7* Days *11* If less than one day
hrs. min.9. Birthplace *York Co., Pa.* (Town, county and state)10. Usual occupation *Watchman*11. Industry or business *Stgo Milling Co*12. Name *John A. Jones*13. Birthplace *Wales*14. Maiden name *Susan Poff*15. Birthplace *York Co., Pa.*16. Informant *Elizabeth Jones*Address *Whitford, Md.*17. Burial Date thereof *Feb 4, 1945* (Burial, cremation, or removal, When?) (month) (day) (year)Cemetery or crematory *Lake Ridge*Location *Delt., Pa.*18. Funeral director *Hugh P. Harkins*Address *Delta, Pa.*19. Date rec'd by registrar *Feb. 4, 1945*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Harford*City or town *Whitford*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

008-07-8623

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 1st - 1945 at 10:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Wednesday, Jan 30th 1945 to Feb 1st 1945*and that I last saw him *alive* on *Feb 1st 1945*

Immediate cause of death

Polyarteritis Thrombosis

DURATION

*1 day*Due to *Thromboembolitis in leg.*

2 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

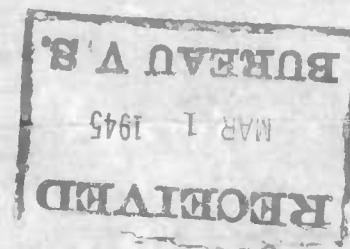
Means of injury

Injured at work?

23. SIGNATURE *Josiah G. Atwell M.D.*

M. D. or other

Address *Cardiff, Md.* Date signed *2/3/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01789

FILM NO. G 94 APR 13 1945

CERTIFICATE OF DEATH

Reg. Distr. No. 182

1. PLACE OF DEATH:

County... Harford

City or town... Rural - Jarrettsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 1/2 years

Hospital, Institution, or street address where death occurred:

Same as above

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Lessner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Married

6. (b) Name of husband or wife

Henry Lessner

7. Birth date of deceased (mo., day, yr.)

7. (c) If alive, give age

76

years

8. AGE:

Years

Months

Days

It less than one day

76

75

10

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Lewis Miller

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Joseph C. Gostomski

Address

Street, Md.

17. Buried

(Burial, cremation, or removal. Which?)

Date thereof February 6, 1945
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Black Rock Pd.

18. Funeral director

Jacob Ulrich & Sons

Address

Manchester - Md.

19. Date rec'd by registrar

2/3 1945

19. Recalla Forward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Harford

City or town... Rural - Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)

Street No... Rural - Federal Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 2, 1945, 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1945 to Feb. 2, 1945

and that I last saw her alive on January 26, 1945

Immediate cause of death Heart Failure

DURATION

Due to Hypertensive Cardio-vascular disease

Due to Essential Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

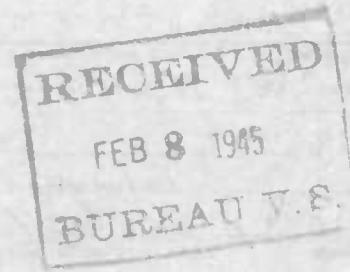
23. SIGNATURE

Charles D. Dofford

M. D. or other

Address Jarrettsville, Md.

Date signed 2-2-45





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VS A15

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

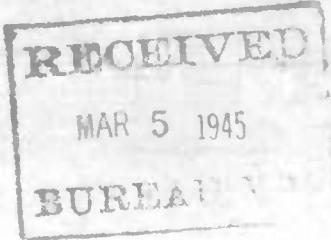
01790

CERTIFICATE OF DEATH

Reg. Diat. No.

96

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... MARYLAND County HARFORD City or town..... DARLINGTON (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... Hospital, Institution, or street address where death occurred:..... How long in hospital or institution?.....			Street No. (If rural, give LOCATION) 2.(a) If veteran, name war..... WORLD WAR II WORLD WAR I			
3. (a) FULL NAME <i>Harry Leon Lovjoy</i>			3. (b) Social Security Number			
4. Sex male Color or race white 5. (a) Single, married, widowed, or divorced <i>Married</i>			MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <i>Mary Ellen Isabell Lovjoy</i>			2D. DATE OF DEATH Feb. 9 1945, at 3 p.m.			
7. Birth date of deceased (mo., day, yr.) <i>April 1, 1895</i>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Feb. 8 1945</i> to <i>Feb. 9 1945</i> and that I last saw him alive on <i>Feb. 8 1945</i>			
8. AGE: Years 49 Months 10 Days 8 If less than one day - hrs. - min.			Immediate cause of death <i>George Peckard</i>			
9. Birthplace <i>Thompson, Vt., U.S.A.</i> (Town, county, and state)			DURATION <i>12 hours</i>			
10. Usual occupation <i>Radio Electrician</i>			Due to.....			
MOTHER FATHER	11. Industry or business <i>H. L. Lovjoy</i>			Due to.....		
	12. Name <i>Albert Remond Lovjoy</i>			Other conditions.....		
MOTHER FATHER	13. Birthplace <i>Maine</i>			(Include pregnancy within 8 months of death)		
	14. Maiden name <i>Ella Helen Black</i>			Major findings of operations..... Date of op.		
MOTHER FATHER	15. Birthplace <i>Maine</i>			Autopsy results.....		
	16. Informant <i>Mary Ellen Isabell Lovjoy</i>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
Address <i>Darlington Md.</i>			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....			
17. BURIAL (Burial, cremation, or removal. Which?) <i>Arlington National Cemetery</i>			Where did injury occur?..... (City or town)..... (County)..... (State).....			
Date thereof <i>Feb. 13 1945</i> (month) (day) (year)			Injured at home, farm, industry, public place (where?).....			
Cemetery or crematory <i>Arlington National Cemetery</i>			Means of Injury..... Injured at work?			
Location <i>Ft. Meyer, Va.</i>			23. SIGNATURE <i>P. Broadgrass</i> M. D. or other			
18. Funeral director <i>See A. Patterson & Son</i>			Address <i>Darlington Md.</i> Date signed <i>2/13/45</i>			
Address <i>Gerryville, Maryland</i>						
19. Date rec'd by registrar <i>Feb. 13 1945</i>						
(Date rec'd by registrar)						



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *2nd*

CERTIFICATE OF DEATH

01791

Reg. Dist. No. 18d

1. PLACE OF DEATH:

County.....

City or town.....

Harford Abingdon Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*Lifetime*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Arthur J. Magness

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Arthur Edward Magness

74

years

7. Birth date of deceased (mo. day. yr.)

April 17, 1866

6. (c) If alive, give age

8. AGE:

Years

78

Months

10

Days

19

If less than one day

hrs.

min.

9. Birthplace.....

Abingdon Harford Md

(Town, county, and state)

10. Usual occupation.....

Carpenter

11. Industry or business

FATHER

12. Name.....

Charles Edward Magness

13. Birthplace

Edmonstone Md

14. Maiden name.....

Mary Jane Whitford

15. Birthplace

Abingdon Md

16. Informant.....

Caroline Magness

Address

Abingdon Md

17. Burial

(Burial, cremation, or removal. Who?)

Burial Mar. 3, 1945

Date thereof

(month)

(day)

(year)

Cemetery or crematory

St. Frances

Location

Abingdon Md

18. Funeral director.....

Harford 10 The Lorraine

Address

Abingdon Md

19. Date reg'd by registrar

Mar. 2, 1945

(Date reg'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Abingdon

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

213-16-9583

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 28*

1945 at 830A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-22

1945

to 2-28

1945

and that I last saw h. m. alive on 2-28

Immediate cause of death *coronary occlusion*

DURATION

1 week

Due to *arterial sclerosis heart disease with hypertension*

years

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Red O Hodson M.D.

M. D. or other

Address *Edgewood Md* Date signed *3-3-45*

RECEIVED

APR 4 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 152

01792

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH:

County..... *Aberdeen*City or town..... *Brunswick* (If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... *Life time*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Clarence E. McCaee

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Male**Colored**Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Dec. 27 - 1944* (c) If alive, give age years8. AGE: Years *1* Months *12* Days *0* If less than one day hrs. min.9. Birthplace..... *Near Aberdeen Md* (Town, county, and state)10. Usual occupation..... *None*

11. Industry or business

FATHER 12. Name..... *Wilton S. McCaee*13. Birthplace..... *Louisiana*MOTHER 14. Maiden name..... *Gussie Robinson*15. Birthplace..... *Texas*16. Informant..... *Mrs. Wilton S. McCaee*Address..... *Aberdeen Md*17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof..... *Feb 10 - 1945* (month) (day) (year)Cemetery or crematory..... *First Cemetery*Location..... *Near Aberdeen Md*18. Funeral director..... *Henry Tarrington Sons*Address..... *Aberdeen Md*

19. Feb. 10 1945 (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Aberdeen*City or town..... *Brunswick* (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Feb 9 - 1945* at *6:20 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19..... 19.....

Immediate cause of death.....

Malnutrition

DURATION

Due to..... *Cause unknown. No further information* *cause* *or* *other*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... *Gerald C. Palmer M.D.* Deputy Medical Examiner M. D. or otherAddress..... *Bethel A. Riley, Md* Date signed..... *2/9/45*

RECEIVED

MAR 3 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITNESSE CORPORATION LIMITED OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

01793

CERTIFICATE OF DEATH

Reg. Distr. No. 185-

1. PLACE OF DEATH: Harford
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, Institution, or street address where death occurred: Harford Memorial Hosp.
 How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Harford
 City or town Perryman.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

William S Monk

3. (b) Social Security Number

717-07-8441

4. Sex <u>M</u>	5. Color or race <u>Negro</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
-----------------	-------------------------------	---

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 16 1882

6.(c) If alive, give age years

8. AGE: Years <u>62</u>	Months <u>5</u>	Days <u>19</u>	If less than one day hrs. min.
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9. Birthplace Perryman Harford, Md.
 (Town, County, and state)10. Usual occupation Section G Aug.11. Industry or business Penca. Rail Road.
 12. Name Robert Monk.13. Birthplace Md.14. Maiden name Elsie Williams15. Birthplace Fla.16. Informant Deceased

Address

17. Burial Burial Date thereof Feb. 6-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union M. E.Location Near Aberdeen Md.18. Funeral director Henry Farren SonsAddress Aberdeen Md.19. Feb. 5 1945 - G. L. Lewis M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 21 1945, to Feb 4 1945,and that I last saw him alive on Feb 4 1945.

Immediate cause of death

ToxemiaDURATION 5 daysDue to Gangrene of foot 1 mo.Due to Diabetes Mellitus >

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

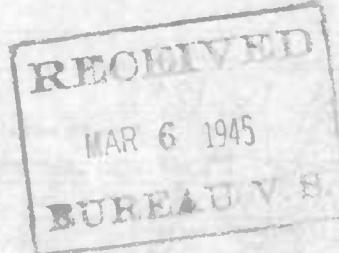
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Charles W. Fugard MDM. D. or other Harford Memorial Hosp.Address Aberdeen Md. Date signed 2-4-45



PLEASE WRITE PLAINLY, WITH EADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

WITHIN CORPORATION LIMITS BY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01794

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford
City or town Holyoke Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days, 23 hrs.

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital
How long in hospital or institution? 3 days, 23 hrs.

3. (a) FULL NAME

William Lewis Morris

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1895 6. (c) If alive, give age years

8. AGE: Years 50 Months 0 Days 4 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Thurman Morris

MOTHER 13. Birthplace Maryland

14. Maiden name Lydia Singleton

15. Birthplace Maryland

16. Informant Howard Morris

Address New Haven de Grace

BURIAL 17. Burial Date thereof 2/22/45
(Burial, cremation, or removal. Which?) month (day) (year)

Cemetery or crematory Rock Run

Location near Churchville Md.

18. Funeral director Tennison & Son

Address Holyoke Grace Md.

19. Date rec'd by registrar Feb. 21 19.45 A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Aldine Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 16, 1945, to Feb. 19, 1945, and that I last saw him alive on Feb. 19, 1945.

Immediate cause of death

Hypertonic pneumonia DURATION 1 day

Due to Fractured skull

Due to Fractured skull DURATION 3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb. 16

Where did injury occur? Aberdeen Bay, Md. (City or town) (County) (State)

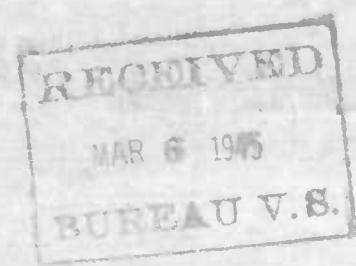
Injured at home, farm, industry, public place (where)? Rock Run Injured at work?

Means of injury hit run driver Injured at work?

23. SIGNATURE

Frank Roberts M.D. M. D. or other

Address Holyoke Grace Date signed Feb. 21



PLEASE WRITE PLAINLY, WITH ~~INK~~ BOLD INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01795

185

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

60 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Michael Henry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Ellen T. Quirk

7. Birth date of deceased (mo., day, yr.)

August 6 - 1870

8. AGE:

Years	Months	Days	If less than one day
74	6	21	hrs. min.

9. Birthplace

France

(Town, county, and state)

10. Usual occupation

Tilling Station Operator/Retired

11. Industry or business

Jewelryman

12. Name

Henry

13. Birthplace

Ireland

14. Maiden name

Bridget Wall

15. Birthplace

Ireland

16. Informant

Mrs. Ellen T. Quirk

Address 55-0 Congress Ave. France

17. Burial

Date thereof 3/26/45

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Zion

Location

France

18. Funeral director

Pennington & Sons

Address

France

19. Date rec'd by registrar

Mar. 26 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 27 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2/27/45Where did injury occur France (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Sagadahock RiverMeans of injury Fell off Pier Injured at work? NoGerald C Palmer M.D.

Deputy Medical Examiner

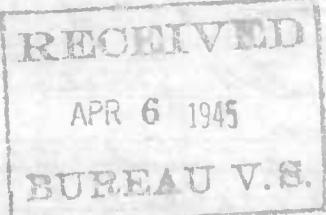
Beltzville, Pa. M. D. or other

Date signed 3/25/45

Address

RECEIVED BY TWENTIETH MEET QUALTRAM

RECEIVED BY STAGHORN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

01796

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:

County.....

Harford

City or town.....

Street, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William H. Ratcliff

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

B. (b) Name of husband or wife.....

Rusha J. Ratcliff

6. (c) If alive, give age.....

60

years

7. Birth date of deceased (mo., day, yr.)

Dec. 8 - 1877

8. AGE:

Years

Months

Days

If less than one day

67

1

27

hrs.

min.

9. Birthplace.....

Richmond Va.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Henry A. Ratcliff

12. Name

Rusha J. Ratcliff

MOTHER FATHER

13. Birthplace

Richmond Va. 18

14. Maiden name

Ella J. White

15. Birthplace

Belfast Va.

16. Informant

Rusha J. Ratcliff

Address

Street, Md.

17. Burial

(Burial, cremation, or removal; Which?) Cemetery or crematory

Date thereof (month) (day) (year)

Cemetery or crematory

Emory cemetery

Location

Street, Md.

18. Funeral director

Hubert H. Harkins

Address

Delta Dr.

19. Date rec'd by registrar

Febr. 6, 1945 M. G. Kirk

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

Street, Rural

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

225-18-9357

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1945 to February 1945,

and that I last saw him alive on February 6 1945.

Immediate cause of death.....

Cardiac failure

Due to..... hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

and Benson 80 years old

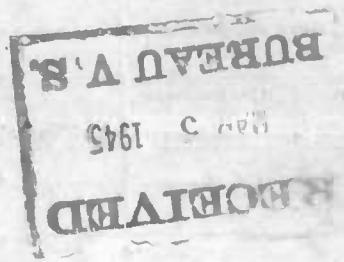
M. D. or other

Address..... Date signed.....

Coral Dell Rd. 2-6-45

Date signed.....

Date signed.....



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1519

CERTIFICATE OF DEATH

01797

185-

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Harford
Harford de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bailey Boy

Richardson.

4. Sex

Male White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Feb. 1, 1945

6. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day
4 hrs. min.

9. Birthplace.....

Harford de Grace, Harford, Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... Ralph Richardson

13. Birthplace..... North Carolina

14. Maiden name..... Ida Hodges

15. Birthplace..... North Carolina

16. Informant.....

Mrs. Ida Richardson

Address..... Bel-Air, Md.

17. Burial..... Date thereof..... Feb. 3, 1945

(month) (day) (year)

Cemetery or crematory..... Arlington Cem.

Location..... Harford Co., Md.

18. Funeral director..... H. S. Bailey

Address..... Arlington, Md.

19. Date rec'd by registrar..... Feb. 2 1945

(Date rec'd by registrar) A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford

City or town..... Belair

(If outside city or town limits, write RURAL and give nearest town)

Street No..... No

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 1, 1945, at 19 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended Deceased from

and that I last saw h. l. m. alive on

Immediate cause of death.....

Atelectasis

Due to.....

Prematurity

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Autopsy results..... lungs collapsed - Not an ordinary
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE

Charles H. Bailey, M.D.

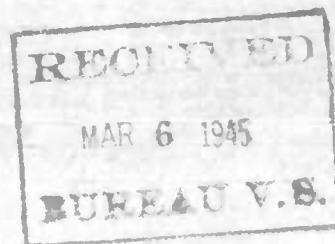
M. D. or other

Address..... Harford de Grace, Md. Date signed..... Feb. 4, 1945

RECEIVED BY THE UNITED STATES GOVERNMENT

BY THE SECRETARY OF STATE

FOR THE RECORDS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITRIM CORPORATION, LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13th

01798

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH:

County Harford
City or town Hause de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 11 days

3. (a) FULL NAME

Frances Richardson4. Sex Female 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Daniel Richardson7. Birth date of deceased (mo., day, yr.) Sept. 30 - 1866 6. (c) If alive, give age years8. AGE: Years 78 Months 4 Days 27 If less than one day hrs. mlo.9. Birthplace Maryland (Town, county, and state)10. Usual occupation. House wife11. Industry or business Daniel Sheridan12. Name Daniel Sheridan13. Birthplace Maryland14. Maiden name Stokes15. Birthplace Maryland16. Informant Frances Richardson (son)Address Bokes St. Hause de Grace17. Burial Date thereof 3/3/45- (Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St. James A. M. E.Location Hause de Grace, Md.18. Funeral director Pennington & SonAddress Hause de Grace, Md.19. Date rec'd by registrar March 3 1945 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Hause de Grace (If outside city or town limits, write RURAL and give nearest town)Street No. 213 North Stokes St. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 28 1945 at 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15 1945 to Feb 28 1945

and that I last saw h. in alive on Feb 28 1945

Immediate cause of death Arturio DelvaneDue to Arturio DelvaneDue to Clarence D. JohnsonDue to Clarence D. Johnson

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other Charles Folger MDAddress Wm. C. Dran Date signed Mar 2/1945

RECEIVED
MAR 6 1946
BUREAU V.S.



MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... Hospital, institution, or street address where death occurred:.....			Street No. (If rural, give LOCATION)			
How long in hospital or institution?.....			2.(a) If veteran, name war.....			
3. (a) FULL NAME <i>Mrs Mary Sewell</i>			3. (b) Social Security Number			
4. Sex <i>Female</i>	5. Color or race <i>W</i>	6.(a) Single, married, widowed, or divorced <i>Widowed</i>	MEDICAL CERTIFICATION			
6.(b) Name of husband or wife <i>Philip Sewell</i>			20. DATE OF DEATH..... <i>Feb 6</i>	19. 45	at 405 p.m.	
7. Birth date of deceased (mo., day, yr.) <i>Aug 7, 1868</i>			21. I CERTIFY that death occurred on the date above stated: that I attended deceased from and that I last saw him..... alive on	19.	19.	
8. AGE: Years <i>76</i>			Immediate cause of death <i>Cerebral hemorrhage</i>	CURATION <i>2 wks.</i>		
Months Days It less than one day hrs. min.						
9. Birthplace <i>MD</i> (Town, county, and state)			Due to... <i>Essential hypertension</i>			
10. Usual occupation <i>Housewife</i>			Due to...			
11. Industry or business			Other conditions <i>decalcites (years?) ca breast</i>			
MOTHER FATHER	12. Name <i>John Morris</i>			(Include pregnancy within 8 months of death)		
	13. Birthplace <i>MD</i>			Major findings of operations <i>none</i>		
	14. Maiden name <i>Martha McConnell</i>			Date of op.		
	15. Birthplace <i>MD</i>			Autopsy results <i>none</i>		
	16. Informant <i>Mrs Harry Hopkins</i>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
Address <i>Bethel, Md</i>			22. VIOLENCE: If death was due to external causes, fill in the following:			
17. Burial (Burial, cremation, or removal. Which?) <i>Burial</i>			Date thereof (month) (day) (year) <i>1945</i>	Accident, suicide, or homicide..... Date of.....		
Cemetery or crematory <i>Jerusalem Christian</i>			Where did injury occur? (City or town) <i>Topps, Md</i>	(County) <i>(State)</i>		
Location <i>Topps, Md</i>			Injured at home, farm, industry, public place (where?) <i>Hospital & Gross</i>			
18. Funeral director <i>Hospital & Gross</i>			Means of Injury <i>Benson, Md</i>	Injured at work?		
Address <i>Benson, Md</i>			23. SIGNATURE <i>Fred O Hodous, M.D.</i>			
19. <i>2/8</i>			Address <i>Edgewood, Md</i>	M. D. or other <i>Edgewood, Md</i>		
19. <i>45</i>			Date signed <i>2-6-45</i>			
(Date fed by registrar)						

VSA

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MAR 6 1945

BUTLER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01800

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County HofordCity or town Cresswell, Bel Air, R.D. #2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leonard Swart

4. Sex

5. Color or race

Male White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age

years

June 13 1867

8. AGE:

Years

Months

Days

If less than one day

57

8

8

hrs.

min.

9. Birthplace.....

Abingdon, Hoford, Md

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

same

12. Name.....

Leonard Swart

13. Birthplace.....

Hoford Co., Maryland

14. Maiden name.....

Mannie Gallion

15. Birthplace.....

Hoford Co., Maryland

16. Informant.....

Mrs. Ella Hughes

Address.....

Cresswell, Bel Air R.D. #2 Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof Feb. 26, 1945

(month) (day) (year)

Cemetery or crematory.....

Abingdon Methodist

Location.....

Abingdon Md (Cottagebury)

18. Funeral director.....

Howard 15. McConaughy

Address.....

Abingdon Maryland

19. Date rec'd by registrar

Feb. 24

1945

Name M. M. Head

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty HofordCity or town Cresswell, Bel Air R.D. #2

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21

1945 at 8:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

now

1945

to Feb 22 1945

and that I last saw him alive on

Feb 22,

1945

Immediate cause of death.....

Acute myocardial infarction, two days

DURATION

Due to..... Coronary Thrombosis

Due to..... Cardiac Failure

Other conditions..... Arteriosclerosis

Cerebral

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed

Feb 25, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95B

CERTIFICATE OF DEATH

01801
Reg. Dist. No. 185

1. PLACE OF DEATH:
 County Harford
 City or town Aberdeen de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Starford Memorial Hospital
 How long in hospital or institution? 1 day

3. (a) FULL NAME

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
Catie Williams
 6. (b) Name of husband or wife Catie Williams

7. Birth date of deceased (mo., day, yr.) December 16, 1890 6. (c) If alive, give age 45 years

8. AGE: Years 54 Months 1 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Pylesville, Harford, Md.
 (Town, county and state)

10. Usual occupation Fireman

11. Industry or business Henry Williams

FATHER 12. Name Henry Williams
 13. Birthplace Starford Co. Md.

MOTHER 14. Maiden name Singer Berry
 15. Birthplace Starford Co. Md.

16. Informant Mrs. Catherine F. Williams

Address Aberdeen Md

17. Burial Date thereof Feb. 19, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys

Location Near Pylesville, Md

18. Funeral director Henry Tarrin Sons

Address Aberdeen Md

19. Feb. 17 1945 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number 218-03-0435

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945 to Feb 15 1945, and that I last saw him alive on Feb 15 1945.

Immediate cause of death

Acute Pulmonary Edema DURATION 18 hrs

Due to Rheumatic heart disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

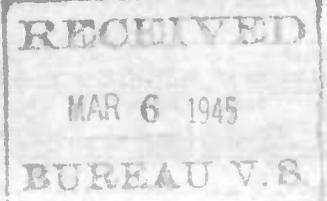
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles H. Legion Jr. M. D. or other _____

Address Harford Memorial Hosp. Date signed 2-15-45



WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

01802

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
 County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 days.
 Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
 How long in hospital or institution? 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md. County Harford
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route #1
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Henry Williamson

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 15, 1867 6. (c) If alive, give age years

8. AGE: Years 77 Months Days If less than one day
 hrs. min.

9. Birthplace Calvert County, Md.
 (Town, county, and state)10. Usual occupation Laborer11. Industry or business On Farm12. Name Henry Williamson13. Birthplace Calvert County, Md.14. Maiden name Kate Grey15. Birthplace Eastern Shore, Md.16. Informant Nellie TurnerAddress Bel-Air, Md.17. Burial Date thereof Feb. 17, 1945
 (Burial, cremation, or removal, Which?) Date (month) (day) (year)Cemetery or crematory Charles Chapel Cem.Location Harford Co. Md.18. Funeral director H. D. BaileyAddress Darlington, Md.19. Date rec'd by registrar Feb. 16, 1945

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 15 1945 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 30 1945 to Feb 15 1945and that I last saw him alive on Feb 15 1945

Immediate cause of death

Toxic myocarditis

Due to

Rheumatic Heart Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Charles H. Lewis Jr.
 Harford Memorial Hosp.
 Havre de Grace, Md.

M. D. or other

Address Havre de Grace, Md. Date signed Feb 15 1945

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MAR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

CERTIFICATE OF DEATH

01803

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Harford
 City or town Havre de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, Institution, or street address where death occurred:
Harford Memorial Hosp.

How long in hospital or institution? 2 days

3. (a) FULL NAME

Katherine Deppish Wilson

4. Sex Female **5. Color or race** White **6. (a) Single, married, widowed, or divorced** Widow

6. (b) Name of husband or wife Harry Scott Wilson

(dece.) **7. Birth date of deceased (mo., day, yr.)** Aug. 12. 1875- **8. (c) If alive, give age** — years

8. AGE: 69 **Years** 5 **Months** 28 **Days** **If less than one day** hrs. min.

9. Birthplace Havre de Grace, Md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business —

FATHER **12. Name** John Deppish

13. Birthplace Maryland

MOTHER **14. Maiden name** Unknown

15. Birthplace Maryland

16. Informant Bethel May Roth

Address 318 S. Union Ave. Havre de Grace

Burial Cemetery **Date thereof** 2/12/45-
 (Burial, cremation, or removal. Which?) **(month) (day) (year)**

Cemetery or crematory Angel Hill
Location Havre de Grace Md.

18. Funeral director Perryman & Son

Address Havre de Grace Md.

19. Date rec'd by registrar 2-12 **19. 45**
 (Date rec'd by registrar) **Q. D. Lewis M.D.**
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 318 S. Union Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9 1945 at 12²⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 **to** **19**

and that I last saw h. alive on **19**

Immediate cause of death Fracture spinal

DURATION 2 days

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 (Date of op.) _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ accident **Date of** 2/8/45

Where did injury occur? Havre de Grace **(City or town)** Harford **(County)** Md. **(State)**

Injured at home, farm, industry, public place (where?) Street

Means of injury Hit by car **Injured at work?** No

De Sales C. Palmer **M.D. or other** De Sales C. Palmer **M.D. or other**

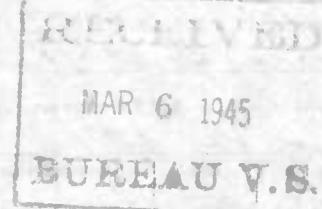
23. SIGNATURE Deputy Medical Examiner

Address Halford County **M. D. or other** Halford County **M. D. or other**

Date signed 2/8/45

ATTACH TO TRANSMISSION REPORTS

ATTACH TO READMISSIONS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

01804

Reg. Dist. No. 185

1. PLACE OF DEATH:

Harford
County Waver de Grace Md
City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 12 hrs.

3. (a) FULL NAME

Baby Wooten

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

S

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Feb. 23 1945
6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

13 hrs. 27 min.

9. Birthplace Waver de Grace, Harford Co., Md
(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name unknown -

13. Birthplace

14. Maiden name Cornelia Wooten

15. Birthplace Natal Bridge, Virginia

16. Informant Josephine Wooten - grandmother

Address 216 Wilson St - Waver de Grace

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 2/25/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Waver de Grace

18. Funeral director Remington & Son

Address Waver de Grace, Md

Feb. 26 1945
(Date rec'd by registrar)A. L. Lewis M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Waver de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 216 Wilson Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 23 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 23 1945 to 1945

and that I last saw deceased on Feb 23 1945

Immediate cause of death

Pneumonia
Due to Birth.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

X-ray results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles H. Holby M.D.
M.D. or other
Address 216 Wilson Street
Date signed 3/23/45

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MAR 6 1945

BUREAU V.S.

1

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 105

CERTIFICATE OF DEATH

118115

183

Reg. Dist. No.

1. PLACE OF DEATH:

County Harford
 City or town Rural - Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Birth

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Earl Wyatt

4. Sex m

5. Color or race w

6.(a) Single, married, widowed, or divorced

Infant

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Jan 9, 1945

8. AGE:

Years	Months	Days	If less than one day
1	1	9	hrs. min.

9. Birthplace

Harford Co, Md

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

12. Name

Charlie Wyatt

13. Birthplace Smyth Co, Va

14. Maiden name Hazel Neal

15. Birthplace Smyth Co, Va

16. Informant Hazel Neal

Address Forest Hill, Md

17. Burial Date thereof Feb 20, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Watters Mem

Location Cocktown, Md.

18. Funeral director Martin J. Kurtz

Address Garretttsville, Md.

19. Date rec'd by registrar Feb 20, 1945 Thomas P. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 2nd County Harford
 City or town Rural - Forest Hill
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Moore Farm
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 20, 1945, at 11:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 - 1945 to Jan 18, 1945

and that I last saw her alive on Jan 16, 1945

Immediate cause of death

Edema of Glottis
Associated with acute

Due to Urticaria

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur? (City or town) (County) (State)

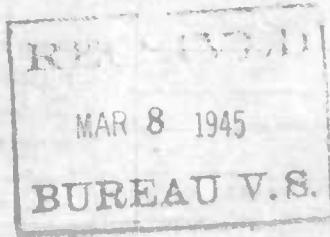
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill, Md. Date signed 2/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

1806

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County

Harford

City or town

Fairfaxville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

19 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pearl Virginia Zinkham

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Joseph C Zinkham

6. (c) If alive, give age, 47 years

7. Birth date of deceased (mo., day, yr.)

March 16 1903

8. AGE:

41

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Athens Smyth Co Va

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Famous Jackson House

12. Name

N.C.

13. Birthplace

Emma Phillips

14. Maiden name

Fox Va

15. Birthplace

Joseph C Zinkham

16. Informant

Forest Hill Rd. Md

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof Ed 26-45

Cemetery or crematory

Wm Waters

Location

Coasttown Hospital & Infir

18. Funeral director

Madeline G. Knobler & Son

Address

Fairfaxville Md.

19. Date rec'd by registrar

Feb 26 1945 Thomas P. Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Fairfaxville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

J

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 23, 1945 at 10³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15, 1944, to Feb 23, 1945,

and that I last saw her alive on Feb. 21, 1945.

Immediate cause of death

Hypostatic pneumonia

DURATION

1 wks.

Due to

Metastatic carcinoma

1 yr.

from right breast

Due to

Other conditions

none.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles A. Duff MD M. D. or other

Address Jarmstown, Md. Date signed Feb 23 1945

